

5699

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 12			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 115 Center St				d. STREET ADDRESS 115 Center St			
3. NAME OF DECEASED (Type or print) First CLARA Middle DELL Last ASHCRAFT				4. DATE OF DEATH Month May Day 29th Year 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 11, 1894		9. AGE (In years last birthday) 61 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY House Work at Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Eugene Pennington				14. MOTHER'S MAIDEN NAME Frances Wilson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Troy S. Ashcraft (Husband) Address 115 Center St. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of Lung, Rt. Lower Lobe 163x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 5/29 19 56 to 5/29 19 56 , that I last saw the deceased alive on 5/27 19 56 , and that death occurred at 12:15 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Rufus S. Gardner, Jr. M.D.				ADDRESS (Street, city or town, state) Peninsula Medical Bldg. S. Division St. Salisbury, Maryland			
PHYSICIAN'S NAME (Type) Dr. Rufus S. Gardner Jr. M.D.				DATE SIGNED May 30 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 31 1956		22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY MARYLAND			
24a. REC'D BY REGISTRAR JUN 1 1956				24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

MEDICAL CERTIFICATION

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF DEATH</p>		<p>7. PLACE OF DEATH</p>		<p>8. CAUSE OF DEATH</p>		<p>9. MANNER OF DEATH</p>		<p>10. SIGNATURE OF REGISTRAR</p>		<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF FUNERAL HOME</p>		<p>13. SIGNATURE OF WITNESSES</p>					
<p>14. NAME OF FUNERAL HOME</p>		<p>15. ADDRESS OF FUNERAL HOME</p>		<p>16. CITY OF FUNERAL HOME</p>		<p>17. STATE OF FUNERAL HOME</p>		<p>18. ZIP CODE OF FUNERAL HOME</p>		<p>19. NAME OF WITNESSES</p>		<p>20. ADDRESS OF WITNESSES</p>		<p>21. CITY OF WITNESSES</p>		<p>22. STATE OF WITNESSES</p>		<p>23. ZIP CODE OF WITNESSES</p>		<p>24. NAME OF PHYSICIAN</p>		<p>25. ADDRESS OF PHYSICIAN</p>		<p>26. CITY OF PHYSICIAN</p>		<p>27. STATE OF PHYSICIAN</p>		<p>28. ZIP CODE OF PHYSICIAN</p>	
<p>29. NAME OF REGISTRAR</p>		<p>30. ADDRESS OF REGISTRAR</p>		<p>31. CITY OF REGISTRAR</p>		<p>32. STATE OF REGISTRAR</p>		<p>33. ZIP CODE OF REGISTRAR</p>		<p>34. NAME OF FUNERAL HOME</p>		<p>35. ADDRESS OF FUNERAL HOME</p>		<p>36. CITY OF FUNERAL HOME</p>		<p>37. STATE OF FUNERAL HOME</p>		<p>38. ZIP CODE OF FUNERAL HOME</p>		<p>39. NAME OF WITNESSES</p>		<p>40. ADDRESS OF WITNESSES</p>		<p>41. CITY OF WITNESSES</p>		<p>42. STATE OF WITNESSES</p>		<p>43. ZIP CODE OF WITNESSES</p>	
<p>44. NAME OF PHYSICIAN</p>		<p>45. ADDRESS OF PHYSICIAN</p>		<p>46. CITY OF PHYSICIAN</p>		<p>47. STATE OF PHYSICIAN</p>		<p>48. ZIP CODE OF PHYSICIAN</p>		<p>49. NAME OF FUNERAL HOME</p>		<p>50. ADDRESS OF FUNERAL HOME</p>		<p>51. CITY OF FUNERAL HOME</p>		<p>52. STATE OF FUNERAL HOME</p>		<p>53. ZIP CODE OF FUNERAL HOME</p>		<p>54. NAME OF WITNESSES</p>		<p>55. ADDRESS OF WITNESSES</p>		<p>56. CITY OF WITNESSES</p>		<p>57. STATE OF WITNESSES</p>		<p>58. ZIP CODE OF WITNESSES</p>	
<p>59. NAME OF REGISTRAR</p>		<p>60. ADDRESS OF REGISTRAR</p>		<p>61. CITY OF REGISTRAR</p>		<p>62. STATE OF REGISTRAR</p>		<p>63. ZIP CODE OF REGISTRAR</p>		<p>64. NAME OF FUNERAL HOME</p>		<p>65. ADDRESS OF FUNERAL HOME</p>		<p>66. CITY OF FUNERAL HOME</p>		<p>67. STATE OF FUNERAL HOME</p>		<p>68. ZIP CODE OF FUNERAL HOME</p>		<p>69. NAME OF WITNESSES</p>		<p>70. ADDRESS OF WITNESSES</p>		<p>71. CITY OF WITNESSES</p>		<p>72. STATE OF WITNESSES</p>		<p>73. ZIP CODE OF WITNESSES</p>	

BUREAU V. B.

JUN 1 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5636

CERTIFICATE OF DEATH

Reg. Dist. No.

05605

335

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharptown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharptown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Main Street		d. STREET ADDRESS Main Street	
3. NAME OF DECEASED (Type or print) First Carl Middle Hermus Last Bennett		4. DATE OF DEATH Month May Day 16 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1, 1879
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY wood	
11. BIRTHPLACE (State or foreign country) Sussex county, Del.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Salithel Bennett		14. MOTHER'S MAIDEN NAME Mary Marine	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-03-4589	
17. INFORMANT Clara Bennett, Sharptown, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Glomerulonephritis DUE TO (b) Arteriosclerosis DUE TO (c) Coronary atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 260X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes		INTERVAL BETWEEN ONSET AND DEATH 12 years 10 years 3 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M., from the causes and on the date stated above.			
ACTUAL SIGNATURE H.S. Kuhlman M.D.		ADDRESS (Street, city or town, state) Sharptown, Md.	
PHYSICIAN'S NAME (Type) H.S. Kuhlman		DATE SIGNED 5/17/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-18-56	
22c. NAME OF CEMETERY OR CREMATORY Taylor		22d. LOCATION (City, town, or county) (State) Sharptown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles H. Marvel - Sharptown, Md.		24. REC'D BY REGISTRAR MAY 22 1956	
ADDRESS		25. REGISTRAR'S SIGNATURE Mary C. Owens	

MEDICAL CERTIFICATION

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be used to certify the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

TO BE FILLED BY THE REGISTRAR OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be filed with the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
Maryland STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 11, 13, 14, See: Birth Cert.
5610
CERTIFICATE OF DEATH

05606
Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>5 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>82 PENINSULA GENERAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>BOLTE</u>				4. DATE OF DEATH Month Day Year <u>MAY 14 1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 9 1956</u>		9. AGE (In years last birthday) yrs. <u>5</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Salisbury, Maryland</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>Lee William Bolte</u>				14. MOTHER'S MAIDEN NAME <u>Janet Louise Pusey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CRANIOSCHISIS</u> <u>758.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/9/56</u> , 19 <u>56</u> to <u>5/14/56</u> , 19 <u>56</u> that I last saw the deceased alive on <u>5-14</u> , 19 <u>56</u> , and that death occurred at <u>5 A.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Morris A. Lambdin</u>				ADDRESS (Street, city or town, state) <u>707 Camden, Salisbury</u>		DATE SIGNED <u>5/14/56</u>	
PHYSICIAN'S NAME (Type) <u>MORRIS A. LAMBDIN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		22b. DATE THEREOF <u>5/15/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Peninsula General Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Peninsula General Hospital</u>				24a. REC'D BY REGISTRAR <u>DATE 5-15-56</u>		24b. REGISTRAR'S SIGNATURE <u>May 15 1956</u>	

2082221XV6

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. DATE OF ENTRY		14. TIME OF ENTRY		15. SIGNATURE OF CLERK	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF WITNESSES		18. SIGNATURE OF FUNERAL HOME	
19. SIGNATURE OF BURIAL SOCIETY		20. SIGNATURE OF CHURCH		21. SIGNATURE OF CEMETERY	
22. SIGNATURE OF OTHER		23. SIGNATURE OF OTHER		24. SIGNATURE OF OTHER	
25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER	
28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	
31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER	
34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER	
37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER		39. SIGNATURE OF OTHER	
40. SIGNATURE OF OTHER		41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER	
43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER		45. SIGNATURE OF OTHER	
46. SIGNATURE OF OTHER		47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER	
49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER		51. SIGNATURE OF OTHER	
52. SIGNATURE OF OTHER		53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER	
55. SIGNATURE OF OTHER		56. SIGNATURE OF OTHER		57. SIGNATURE OF OTHER	
58. SIGNATURE OF OTHER		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER	
61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER		63. SIGNATURE OF OTHER	
64. SIGNATURE OF OTHER		65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER	
67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER		69. SIGNATURE OF OTHER	
70. SIGNATURE OF OTHER		71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER	
73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER	
76. SIGNATURE OF OTHER		77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER	
79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER		81. SIGNATURE OF OTHER	
82. SIGNATURE OF OTHER		83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER	
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94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER	
97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER	
100. SIGNATURE OF OTHER		101. SIGNATURE OF OTHER		102. SIGNATURE OF OTHER	

RECEIVED
MAY 17 1956
BUREAU V. 2

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

Dr. - Long, Brice,
Fisher

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

05607

5611

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>			
CITY OR TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY OR TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pen. Gen. Hospital</u>				STREET ADDRESS (if rural give location) <u>500 Hammond St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Alex</u>		(Middle) <u>BURTON</u>		(Last) <u>BURTON</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>Oct. 13, 1896</u>	
9. AGE last birthday <u>59</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New York City, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Solomon Brinkowitz</u>				14. MOTHER'S MAIDEN NAME <u>Dora Gilliam</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>UNK</u>				16. SOCIAL SECURITY NO. <u>151 X</u>			
17. INFORMANT & ADDRESS <u>Mrs. Blanche Burton (Wife) 500 Hammond St. Salisbury, Md.</u>							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
151 X IMMEDIATE CAUSE (A) <u>Generalized Carcinomatosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 mon</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma of Stomach</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 19....., to 19....., that I last saw the deceased alive on 19....., and that death occurred at <u>6:35 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>W. Brice</u>				ADDRESS (Street, city, town, state) <u>New York</u> DATE SIGNED <u>5-30-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>June 1, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cemetery - New York</u>		LOCATION (City, town, or county) (State)	
24. REGD. BY REGISTRAR <u>JUN 1 1956</u>		REGISTRAR'S SIGNATURE <u>Mary H. Hollaway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Hollaway Company - Salisbury Md.</u>		ADDRESS	

CERTIFICATE OF DEATH

FILE NO.

DATE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF ARRIVAL

PLACE OF ARRIVAL

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DATE OF RETURN

PLACE OF RETURN

BUREAU V.

JUN 1 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5637

CERTIFICATE OF DEATH

05608

Reg. Dist. No.

33 y

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 3				d. STREET ADDRESS R.D.# 3			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JAMES Middle W Last CALLOWAY				4. DATE OF DEATH Month MAY Day 9 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 8, 1864	9. AGE (In years last birthday) 92 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Wicomico Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME No Record				14. MOTHER'S MAIDEN NAME No Record			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Fannie C. Parker (Daughter) R.D.# 3 Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hyphostates Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Erythema of left temporal region & eye DUE TO (c) 6 yrs						INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 1, 1965 , to May 9, 1966 , that I last saw the deceased alive on May 8, 1966 , and that death occurred at 3:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE S. H. Lynch M.D.				ADDRESS (Street, city or town, state) Delmar, Delaware			
DATE SIGNED May 9 1956							
PHYSICIAN'S NAME (Type) Dr. S.H. Lynch M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 11, 1956		22c. NAME OF CEMETERY OR CREMATORY Charity Church Cemetery		22d. LOCATION (City, town, or county) (State) R.D.# Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR DATE 5/11/56	
				24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5612

CERTIFICATE OF DEATH

05609

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		d. STREET ADDRESS 220 Record St	
3. NAME OF DECEASED (Type or print) First MAMIE Middle Last COLLINS		4. DATE OF DEATH Month May Day 30 Year th 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH (Unk) 1877
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired School Teacher (and) House Work		10b. KIND OF BUSINESS OR INDUSTRY R.D. # Salisbury Md.	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME B. Sidney Morris		14. MOTHER'S MAIDEN NAME Josephine Dykes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Walter Collins—(Husband) Address 220 Records St Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 48 hrs
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1944 to May 30, 1956 , that I last saw the deceased alive on 12 , and that death occurred at 5:35 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Philip A Insley M.D. Salisbury Md.		DATE SIGNED June 29 1956	
PHYSICIAN'S NAME (Type) Philip A Insley			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 2, 1956	22c. NAME OF CEMETERY OR CREMATORY Morris Family Cemetery	22d. LOCATION (City, town, or county) (State) R.D. # Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND		24a. RECEIVED BY REGISTRAR JUN 4 24b. REGISTRAR'S SIGNATURE Mary St. Holloway	

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

9551 15 NTH

RECEIVED

TO HOSPITALS OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5613
CERTIFICATE OF DEATH

05610

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>125 Salisbury</u>				c. LENGTH OF STAY IN 1b <u>27 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>82 Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>J.</u> Last <u>Cubler</u>				4. DATE OF DEATH Month <u>May</u> Day <u>23</u> Year <u>1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 4-1889</u>	9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stammer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u>		11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Pa</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Andrew Cubler</u>				14. MOTHER'S MAIDEN NAME <u>Annie Kline</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>035-07-7476A</u>		17. INFORMANT Address <u>Mrs. Grace M. Cubler, Snow Hill, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>154x Metastatic Carcinoma Brain</u> DUE TO " " <u>Carcinoma Lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of rectum</u> (c) <u>2 years</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>6 months</u> <u>2 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from _____, 19____, to <u>5-23</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5-23</u> , 19 <u>56</u> , and that death occurred at <u>Liba, Md.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. J. Ellis, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Md</u> DATE SIGNED <u>5-23-56</u>			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>May 24/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>William Wilson Co</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne Simms, Snow Hill, Md</u>				24. RECD BY REGISTRAR <u>MAY 28 1956</u>		25. REGISTRAR'S SIGNATURE <u>Mary St. Holloway</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
JAMES H. HARRIS		45		M		W		1880		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH		PERIOD OF ILLNESS		PLACE OF DEATH		CITY		COUNTY	
Carpenter		High School		Married		Catholic		Heart Disease		3 weeks		BALTIMORE		BALTIMORE		BALTIMORE	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE		DATE OF BURIAL		TIME OF BURIAL		PLACE OF BURIAL	
May 28, 1956		10:00 AM		Home		BALTIMORE		BALTIMORE		BALTIMORE		May 29, 1956		1:00 PM		Catholic Cemetery	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF FUNERAL HOME		SIGNATURE OF CHURCH		SIGNATURE OF MINISTERS		SIGNATURE OF OTHERS		SIGNATURE OF OTHERS	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	

BUREAU V. 3

MAY 28 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05611

5638

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Mardela</u>		<u>33 Yrs.</u>		TOWN <u>Mardela</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<u>Main Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Iva</u> (Middle) <u>M.</u> (Last) <u>Dunn</u>				(Month) <u>May</u> (Day) <u>17</u> (Year) <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F</u>	<u>White</u>	<u>Married</u>	<u>May 30, 1885</u>	<u>70</u> yrs.	Months <u>11</u>	Days <u>17</u>	Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Own Home</u>		<u>Bivalve, Maryland</u>		<u>U.S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>George B. Horsman, Sr.</u>				<u>Margaret Ellen Anderson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>				<u>Victor Dunn, Mardela, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>CORONARY OCCLUSION</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>DIABETES MELLITUS</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>HYPERTENSION</u>							
260X							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>NONE</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>NONE</u>		<u>NONE</u>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
				<u>NONE</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>NONE</u>		<u>NONE</u>		<u>NONE</u>			
22. I hereby certify that I attended the deceased from <u>5/16</u> , 19 <u>56</u> , to <u>5/16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5/16</u> , 19 <u>56</u> , and that death occurred at <u>1:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city, town, state) <u>Mardela, Maryland</u>		DATE SIGNED <u>5/18/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5/20/56</u>		<u>Bivalve Cem.</u>		<u>Bivalve, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>MAY 28 1956</u>		<u>Mary H. Holloway</u>		<u>Emeline D. Pearson, Bivalve, Md.</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Reg. No. 100

1. PLACE WHERE DEATH OCCURRED

2. NAME OF DECEASED

3. SEX

4. AGE

5. DATE OF BIRTH

6. PLACE OF BIRTH

7. OCCUPATION

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. DATE OF DEATH

13. TIME OF DEATH

14. PLACE OF DEATH

15. SIGNATURE OF DECEASED

16. SIGNATURE OF WITNESSES

17. SIGNATURE OF CLERGYMAN

18. SIGNATURE OF BURIAL OFFICIAL

19. SIGNATURE OF FUNERAL HOME

20. SIGNATURE OF CEMETERY

21. SIGNATURE OF INTERVIEWER

22. SIGNATURE OF INTERVIEWER

23. SIGNATURE OF INTERVIEWER

24. SIGNATURE OF INTERVIEWER

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56. SIGNATURE OF INTERVIEWER

57. SIGNATURE OF INTERVIEWER

58. SIGNATURE OF INTERVIEWER

BUREAU V. 3

MAY 28 1956

RECEIVED

Mary H. Williams

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled in by the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05612

5639

CERTIFICATE OF DEATH

Reg. Dist. No. 336

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Delaware</u>		COUNTY <u>New Castle</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Delmar</u>		LENGTH OF STAY (in this place) <u>2 1/2 mos.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Wilmington</u>		<u>46X-9</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>At home - Delmar</u>				STREET ADDRESS (If rural give location) <u>404 E. 9th Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>John Henry Elzey</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>5 - 17 - 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>A.A.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1886</u>		9. AGE last birthday <u>70 yrs.</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stevadore</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ship Yard</u>		11. BIRTHPLACE (State or foreign country) <u>Nanticoke, Wicomico Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Elzey</u>				14. MOTHER'S MAIDEN NAME <u>Laura Washington</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>222-01-5927</u>		17. INFORMANT & ADDRESS <u>Mrs. Irene Elzey Vincent, Laurel, Del.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
151X IMMEDIATE CAUSE (A) <u>Internal Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma of stomach</u>				<u>2 yrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March</u>, 19<u>56</u>, to <u>May 17</u>, 19<u>56</u>, that I last saw the deceased alive on <u>May 14</u>, 19<u>56</u>, and that death occurred at <u>3:30</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>St. Lynch</u>				DATE SIGNED <u>Delmar</u>		ADDRESS (Street, city, town, state) <u>Laurel, Sussex Co., Del.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5-20-56</u>		NAME OF CEMETERY OR CREMATORY <u>Laurel Cemetery</u>		LOCATION (City, town, or county) (State) <u>Laurel, Sussex Co., Del.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Harry E. Hudson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mary A. Stewart</u>		ADDRESS <u>J. F. Stewart Funeral Home, Salisbury, Md.</u>	
DATE <u>MAY 21 1956</u>							

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

Page 1 of 1

1. Name of deceased (Print or type)

2. Date of death (Print or type)

3. Place of death (Print or type)

4. Sex (Print or type)

5. Age (Print or type)

6. Race (Print or type)

7. Cause of death (Print or type)

8. Date of death (Print or type)

9. Sex (Print or type)

10. Race (Print or type)

11. Age (Print or type)

12. Place of death (Print or type)

13. Date of death (Print or type)

14. Sex (Print or type)

15. Race (Print or type)

16. Age (Print or type)

17. Date of death (Print or type)

18. Sex (Print or type)

19. Race (Print or type)

20. Age (Print or type)

21. Date of death (Print or type)

22. Sex (Print or type)

23. Race (Print or type)

24. Age (Print or type)

25. Date of death (Print or type)

26. Sex (Print or type)

27. Race (Print or type)

28. Age (Print or type)

29. Date of death (Print or type)

30. Sex (Print or type)

31. Race (Print or type)

32. Age (Print or type)

33. Date of death (Print or type)

34. Sex (Print or type)

35. Race (Print or type)

36. Age (Print or type)

37. Date of death (Print or type)

38. Sex (Print or type)

39. Race (Print or type)

40. Age (Print or type)

41. Date of death (Print or type)

42. Sex (Print or type)

43. Race (Print or type)

44. Age (Print or type)

45. Date of death (Print or type)

46. Sex (Print or type)

47. Race (Print or type)

48. Age (Print or type)

49. Date of death (Print or type)

50. Sex (Print or type)

51. Race (Print or type)

52. Age (Print or type)

53. Date of death (Print or type)

54. Sex (Print or type)

55. Race (Print or type)

56. Age (Print or type)

57. Date of death (Print or type)

58. Sex (Print or type)

59. Race (Print or type)

60. Age (Print or type)

61. Date of death (Print or type)

62. Sex (Print or type)

63. Race (Print or type)

64. Age (Print or type)

BUREAU V. S.

MAY 21 1956

RECEIVED

May 21 1956

NOTIFICATION

This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, and a copy of the same is to be sent to the local health officer of the jurisdiction in which the death occurred. The local health officer is to be notified of the death of the deceased by the Registrar of the State Department of Health, Baltimore, Maryland, and a copy of the same is to be sent to the local health officer of the jurisdiction in which the death occurred. The local health officer is to be notified of the death of the deceased by the Registrar of the State Department of Health, Baltimore, Maryland, and a copy of the same is to be sent to the local health officer of the jurisdiction in which the death occurred.

5640

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverton				c. LENGTH OF STAY IN 1b 50 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Ada Middle Kennerly Last English				4. DATE OF DEATH Month May Day 29 Year 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 22, 1892	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Riverton, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George T. Kennerly				14. MOTHER'S MAIDEN NAME Anna Robinson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT William Rodney English, Riverton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC NEPHRITIS DUE TO CHRONIC MYOCARDITIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO DIABETES MELLITUS (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/29 , 19 56 , to 5/29 , 19 56 , that I last saw the deceased alive on May 29 , 19 56 , and that death occurred at 12:53 M., from the causes and on the date stated above.							
ACTUAL SIGNATURE W.E. Spitznogle M.D.				ADDRESS (Street, city or town, state) Maryland			
PHYSICIAN'S NAME (Type) W.E. SPITZNOGLE M.D.				DATE SIGNED May 29, 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-31-56		22c. NAME OF CEMETERY OR CREMATORY Riverton Methodist		22d. LOCATION (City, town, or county) (State) Riverton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles W. Marshall				ADDRESS Shapton		24a. REC'D BY REGISTRAR WIN 4 1956	
				24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

5614

CERTIFICATE OF DEATH

05614

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seaford</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>R.F.D. # 3</u>	
3. NAME OF DECEASED (Type or print) First <u>Mildred</u> Middle <u>S.</u> Last <u>ESKRIDGE</u>		4. DATE OF DEATH Month <u>May</u> Day <u>27</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 7, 1897</u>
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Luther C. Wheatley</u>		14. MOTHER'S MAIDEN NAME <u>Suphene Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>E. S. ESKRIDGE, RD 3 Seaford Del</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Atherosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Myocardial Insufficiency</u>		INTERVAL BETWEEN ONSET AND DEATH <u>one week</u> <u>2 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 55</u> to <u>May 27, 1956</u> , that I last saw the deceased alive on <u>May 26, 1956</u> , and that death occurred at <u>11:00 A.M.</u> from the causes and on the date stated above.		DATE SIGNED <u>5/27/56</u>	
ACTUAL SIGNATURE <u>Paul J. Schiore</u> M.D.		ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type)		DATE	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/30/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Freemans Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Seaford Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Barney Williamson, Seaford Del.</u>		24a. REC'D BY REGISTRAR <u>May 1 1956</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 10

<p>1. NAME OF DECEASED [Faint, illegible text]</p>		<p>2. SEX [Faint, illegible text]</p>	
<p>3. AGE [Faint, illegible text]</p>		<p>4. DATE OF BIRTH [Faint, illegible text]</p>	
<p>5. PLACE OF BIRTH [Faint, illegible text]</p>		<p>6. DATE OF DEATH [Faint, illegible text]</p>	
<p>7. TIME OF DEATH [Faint, illegible text]</p>		<p>8. PLACE OF DEATH [Faint, illegible text]</p>	
<p>9. CAUSE OF DEATH [Faint, illegible text]</p>		<p>10. MANNER OF DEATH [Faint, illegible text]</p>	
<p>11. SIGNATURE OF DECEASED [Faint, illegible text]</p>		<p>12. SIGNATURE OF WITNESS [Faint, illegible text]</p>	
<p>13. SIGNATURE OF PHYSICIAN [Faint, illegible text]</p>		<p>14. SIGNATURE OF CORONER [Faint, illegible text]</p>	
<p>15. SIGNATURE OF JURY [Faint, illegible text]</p>		<p>16. SIGNATURE OF JUDGE [Faint, illegible text]</p>	

BUREAU V. I.

JUN 1 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5641

CERTIFICATE OF DEATH

Reg. Dist. No.

05615
332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>1 month</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				d. STREET ADDRESS <u>Quantico</u>			
3. NAME OF DECEASED (Type or print) First <u>Georgianna</u> Middle <u>Gale</u> Last <u>Gale</u>				4. DATE OF DEATH Month <u>May</u> Day <u>23</u> Year <u>19 56</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 21, 1898</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Quantico, Md.</u>	
13. FATHER'S NAME <u>George Goslee</u>				14. MOTHER'S MAIDEN NAME <u>Mahala Goslee</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>2-13-18-45B</u>		17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>026X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Meningovascular syphilis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>?</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 16</u> , 19 <u>56</u> , to <u>May 23</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 23</u> , 19 <u>56</u> , and that death occurred at <u>1:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Deer's Head Hospital; Salisbury, Md.</u> DATE SIGNED <u>5/23/56</u> ACTUAL SIGNATURE <u>V. Juerman</u> PHYSICIAN'S NAME (Type) <u>V. Juerman, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-27-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Head of Creek</u>		22d. LOCATION (City, town, or county) (State) <u>Head of Creek Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Boaker M. West</u>				ADDRESS <u>Salisbury, Md.</u>		24a. REC'D BY REGISTRAR <u>5-28-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in payment within 72 hours after death.

BUREAU V. S.

1956 7 JUN

RECEIVED

5615

CERTIFICATE OF DEATH

Reg. Dist. No.

05616

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wic.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>206 Walnut St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Marguerite</u> Middle <u>Gillis</u> Last <u>Gillis</u>				4. DATE OF DEATH Month <u>May</u> Day <u>17</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 4, 1955</u>	
9. AGE (In years last birthday) yrs. <u>5</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		9. AGE (In years last birthday) Months <u>5</u> Days <u>13</u> Hours <u></u> Min. <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Salisbury, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>			
13. FATHER'S NAME <u>Dr. Marion Gillis</u>				14. MOTHER'S MAIDEN NAME <u>Marguerite Jackson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u></u>			
17. INFORMANT Address <u>Dr. Marion Gillis (Father) 206 Walnut St. Salisbury, Maryland</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>493X Respiratory Failure</u> DUE TO (b) <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>7 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mongolian + Congenital Heart Disease</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>5/10</u> , 19 <u>56</u> , to <u>5/17</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5/16</u> , 19 <u>56</u> , and that death occurred at <u>10:50</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William C. Morgan</u> M.D. <u>Salisbury, Md</u>				ADDRESS (Street, city or town, state) <u>Salisbury, Md</u>			
DATE SIGNED <u>5/17/56</u>							
PHYSICIAN'S NAME (Type) <u>Dr. William C. Morgan</u> <u>Medical Center-Salisbury, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 19, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u>				24a. REC'D BY REGISTRAR <u>MAY 21 1956</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

2082422414

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 21 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05617

5616 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury		LENGTH OF STAY (In this place) All life		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 315 Poplar Hill Ave.				STREET ADDRESS (If rural give location) 315 Poplar Hill Ave.			
3. NAME OF DECEASED (Type or Print) Joseph Gray				4. DATE OF DEATH 5 - 18 - 19 56			
5. SEX Male		6. COLOR OR RACE A.A.		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed		8. DATE OF BIRTH 1902	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hod Carrier		10b. KIND OF BUSINESS OR INDUSTRY Masonry		9. AGE last birthday 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Salisbury, Wicomico Co., Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Major Gray				14. MOTHER'S MAIDEN NAME Belle Dixon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 222-01-5862		17. INFORMANT & ADDRESS 305 Poplar Hill Ave. Mrs. Miranda Dixon, Salisbury, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) Hypertensive Cardiovascular Renal Disease						INTERVAL BETWEEN ONSET AND DEATH 6 months	
ANTECEDENT CAUSE(S) DUE TO (B) Hypertension						Indefinite	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) Arteriosclerosis						Indefinite	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 17 Dec. , 19 55 , to 18 May , 19 56 , that I last saw the deceased alive on 18 May , 19 56 , and that death occurred at 6:00 M. from the causes and on the date stated above.							
SIGNATURE Starnell		M.D. 612 W main		ADDRESS (Street, city, town, state) Salisbury, Md		DATE SIGNED 18 May 56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 5-21-56		NAME OF CEMETERY OR CREMATORY Green Acres Mem. Park		LOCATION (City, town, or county) Salisbury, Wicomico Co. Md.	
24. REC'D BY REGISTRAR Mary H. Hallaway		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart			
DATE MAY 21 1956		ADDRESS J. F. Stewart Funeral Home, Salisbury, Md.					

2015 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Part I - Cause of Death

1. (ICD-10) Cause of Death

2. (ICD-10) Cause of Death

3. (ICD-10) Cause of Death

4. (ICD-10) Cause of Death

5. (ICD-10) Cause of Death

6. (ICD-10) Cause of Death

7. (ICD-10) Cause of Death

8. (ICD-10) Cause of Death

9. (ICD-10) Cause of Death

10. (ICD-10) Cause of Death

11. (ICD-10) Cause of Death

12. (ICD-10) Cause of Death

13. (ICD-10) Cause of Death

14. (ICD-10) Cause of Death

15. (ICD-10) Cause of Death

16. (ICD-10) Cause of Death

17. (ICD-10) Cause of Death

18. (ICD-10) Cause of Death

19. (ICD-10) Cause of Death

20. (ICD-10) Cause of Death

21. (ICD-10) Cause of Death

22. (ICD-10) Cause of Death

23. (ICD-10) Cause of Death

24. (ICD-10) Cause of Death

25. (ICD-10) Cause of Death

26. (ICD-10) Cause of Death

27. (ICD-10) Cause of Death

28. (ICD-10) Cause of Death

29. (ICD-10) Cause of Death

30. (ICD-10) Cause of Death

BUREAU V. S.

MAY 21 1955

RECEIVED

James H. Holloman

INSTRUCTIONS

1. This certificate is to be filled out by the physician or other qualified person who has attended the deceased or who has been in attendance at the death. It is to be filled out in the case of all deaths, whether or not the death was expected, and whether or not the death was due to natural causes. It is to be filled out in the case of all deaths, whether or not the death was expected, and whether or not the death was due to natural causes. It is to be filled out in the case of all deaths, whether or not the death was expected, and whether or not the death was due to natural causes.

5617

CERTIFICATE OF DEATH

05618

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> 12	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>816 E. Church St.</u> 1	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lemuel</u> <u>BLUM</u> <u>Hewitt</u>		4. DATE OF DEATH Month Day Year <u>May</u> <u>29</u> <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 18 - 1883</u> 73 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabinet Maker (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Employee of Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Chance, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>James Hewitt</u>		14. MOTHER'S MAIDEN NAME <u>Unk</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk</u>		16. SOCIAL SECURITY NO. <u>Unk</u>	
17. INFORMANT <u>Mrs. Ruth Foskey (Daughter)</u>		Address <u>816 E. Church St Salisbury, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED White at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to <u>5-30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5-30</u> , 19 <u>56</u> , and that death occurred at <u>8:55 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. R. Ellis Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Md</u> DATE SIGNED <u>5-30-56</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Wilber R. Ellis Jr. MD</u>		Medical Center Salisbury, Maryland 5/30/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 1, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>	
24a. REC'D BY REGISTRAR <u>JUN 1 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4C may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. AND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

1956 JUN 1

RECEIVED
JUN 1 1956

5518

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 4 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henderson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Jane Last Jenkins				4. DATE OF DEATH Month May Day 29 Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/17/1878	
				9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Samaule Thorpe				14. MOTHER'S MAIDEN NAME Martha Leager			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. -- --		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerosis, general DUE TO (c) Hypertensive arteriosclerotic cardiovascular disease							INTERVAL BETWEEN ONSET AND DEATH 3 days ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertensive arteriosclerotic cardiovascular disease							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -- --					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 25 , 19 56 , to May 29 , 19 56 , that I last saw the deceased alive on May 29 , 19 56 , and that death occurred at 7:05 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE V. Juerman		M.D. Deer's Head State Hospital		ADDRESS (Street, city or town, state) Salisbury, Maryland		DATE SIGNED 5/30/56	
PHYSICIAN'S NAME (Type) V. Juerman, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/2/56		22c. NAME OF CEMETERY OR CREMATORY Lakes Side Cem.		22d. LOCATION (City, town, or county) (State) Dover, Del.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Wells & Fairer		ADDRESS Smyrna, Del.		24. RECD BY REGISTRAR MAY 31 1956		24b. REGISTRAR'S SIGNATURE Mary K. Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

334

RECEIVED
MAY 31 1956
BUREAU V. 3

5619

CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>WICOMICO COUNTY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>DEER'S HEAD STATE HOSPITAL</u>				d. STREET ADDRESS <u>109 EAST CHESTNUT ST.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WALTER LLOYD JOHNSON</u>				4. DATE OF DEATH Month Day Year <u>MAY 4 1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 6, 1882</u>		9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNKNOWN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>UNKNOWN</u>		11. BIRTHPLACE (State or foreign country) <u>SOMERSET COUNTY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HENRY JAMES JOHNSON</u>				14. MOTHER'S MAIDEN NAME <u>MARY ANN BOSTON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>163X GENERALIZED CARCINOMATOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>260X</u> (b) <u>CARCINOMA OF LUNG WITH METASTASIS</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>DIABETES MELLITUS</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/1/54</u> , 19 <u>54</u> , to <u>5/4/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5/4/56</u> , 19 <u>56</u> , and that death occurred at <u>6:55 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.				PHYSICIAN'S NAME (Type) <u>R. J. GORE</u> M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 7, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Crisfield Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Crisfield Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bradshaw & Sons</u>				ADDRESS <u>Crisfield, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>5-12-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Maryll Holloway</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

BUREAU V. S.

MAY 15 1956

RECEIVED

5620

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH o. COUNTY <i>Wicomico</i> md MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md</i> b. COUNTY <i>Wicomico</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury md</i>		c. LENGTH OF STAY IN 1b <i>Life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Gen Gen Hosp</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Beatrice</i> Middle <i>P.</i> Last <i>Jones</i>		4. DATE OF DEATH Month <i>May</i> Day <i>3</i> Year <i>1956</i>	
5. SEX <i>F.</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 15, 1904</i>
9. AGE (In years last birthday) <i>50</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
11. BIRTHPLACE (State or foreign country) <i>Va</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>George Custus</i>		14. MOTHER'S MAIDEN NAME <i>Anna Davis</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Willie Jones</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Coronary Insufficiency</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>the</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>unk</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Carcinoma of Breasts - Hypertension</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY, Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May 2, 1956</i> , to <i>May 3, 1956</i> , that I last saw the deceased alive on <i>May 2, 1956</i> , and that death occurred at <i>8:40</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>G. Herbert Semblly</i> M.D.		DATE SIGNED <i>5/5/56</i>	
PHYSICIAN'S NAME (Type) <i>G. Herbert Semblly</i>		ADDRESS (Street, city or town, state) <i>Salisbury Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>5-5-56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Green Heron</i>	22d. LOCATION (City, town, or county) (State) <i>Salisbury Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Barker M. Luet</i>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <i>5-8-56</i>		24b. REGISTRAR'S SIGNATURE <i>Chas. W. Holman</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 78

CERTIFICATE OF DEATH

See: Birth Cert:

5621

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SNOW HILL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>WASHINGTON STREET</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>KILLMON</u>				4. DATE OF DEATH Month Day Year <u>MAY 16 1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 16 1956</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Salisbury, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Richard Killmon</u>				14. MOTHER'S MAIDEN NAME <u>Audrey Elizabeth Groton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>758.1</u> <u>Congenital Achromatopsia</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>25 Min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>5/16</u> , 19 <u>56</u> , to <u>5/16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5/16</u> , 19 <u>56</u> , and that death occurred at <u>2:15</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph La Mar</u>				ADDRESS (Street, city or town, state) <u>104 Bay St., Snow Hill, Md.</u>			
PHYSICIAN'S NAME (Type) _____				DATE SIGNED <u>5/16/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>5-16-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Peninsula General Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Wicomico Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Peninsula General Hospital</u>				24a. REC'D BY REGISTRAR <u>Manuel H. Halloway</u>		24b. REGISTRAR'S SIGNATURE	

2082282XV2

TO HAVE THIS CERTIFICATE VALID FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAY 18 1956

RECEIVED

5642

CERTIFICATE OF DEATH

05623

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 402 Pine Street				d. STREET ADDRESS 402 Pine Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Anna Middle Lawrence Last Lawrence				4. DATE OF DEATH Month May Day 12 Year 1956			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 16, 1889	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months 67 Days 67 Hours 67 Min. 67		IF UNDER 24 HRS. Months 67 Days 67 Hours 67 Min. 67			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Pants Factory		11. BIRTHPLACE (State or foreign country) Philadelphia, Pa		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James B. Lawrence				14. MOTHER'S MAIDEN NAME Anna Paulin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Ida Stephens, Delmar, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Cardiac Dilatation 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Chronic Myocarditis (b) Chronic Myocarditis (c) Chronic Myocarditis						INTERVAL BETWEEN ONSET AND DEATH few months 4 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan 10 19 56 to May 12 19 56 , that I last saw the deceased alive on May 10 19 56 , and that death occurred at Delmar, Md from the causes and on the date stated above.							
ACTUAL SIGNATURE L. H. Lynch M.D. Delmar, Del				DATE SIGNED May 12			
PHYSICIAN'S NAME (Type) L. H. Lynch				Delmar, Del			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-15-56		22c. NAME OF CEMETERY OR CREMATORY Chelton Hills		22d. LOCATION (City, town, or county) (State) Philadelphia, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE W. S. Mansel Co - Delmar, Del ADDRESS Delmar, Del				24a. REC'D BY REGISTRAR 5/14/56		24b. REGISTRAR'S SIGNATURE Harry E. Hudson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

100-100

100-100

BUREAU V. S.

MAY 14 1956

RECEIVED

5622

CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 5 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital				d. STREET ADDRESS 708 Smith St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First LEVI Middle LEE Last LAWS				4. DATE OF DEATH Month 5 Day 8 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 8, 1862	
9. AGE (In years last birthday) 93 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Lumberman		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William L. Laws				14. MOTHER'S MAIDEN NAME Margaret Fooks			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Lester Laws Address Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-Pneumonia 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Thrombosis DUE TO (c) 4 days INTERVAL BETWEEN ONSET AND DEATH 3 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1946 , to 5/8 , 19 56 , that I last saw the deceased alive on 5/8 , 19 56 , and that death occurred at 3:10 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Fred R. Gramse M.D. Salisbury, Md DATE SIGNED 5/10/56				ADDRESS (Street, city or town, state)			
PHYSICIAN'S NAME (Type) FRED R. GRAMSE - M.D. 402 S. Division St., Salisbury, Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/11/1956		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE George C. This ADDRESS Salisbury, Maryland				24a. REC'D BY REGISTRAR DATE 5-10-56		24b. REGISTRAR'S SIGNATURE Mary M. Holloray	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JOHN J. JOSEPH		DATE OF DEATH MAY 11 1956		PLACE OF DEATH ALBANY, N.Y.	
AGE 34		SEX MALE		RACE WHITE	
BIRTH DATE MAY 11 1922		BIRTH PLACE ALBANY, N.Y.		EDUCATION HIGH SCHOOL	
OCCUPATION LABORER		MARRIAGE MAY 11 1956		CAUSE OF DEATH HEART DISEASE	
DISEASE OR INJURY CORONARY ARTERY DISEASE		IMMEDIATE CAUSE MYOCARDIAL INFARCTION		MANNER OF DEATH NATURAL	
SIGNATURE OF DECEASED JOHN J. JOSEPH		SIGNATURE OF WITNESS JOHN J. JOSEPH		SIGNATURE OF PHYSICIAN JOHN J. JOSEPH	
DATE OF SIGNATURE MAY 11 1956		DATE OF SIGNATURE MAY 11 1956		DATE OF SIGNATURE MAY 11 1956	

BUREAU V. S.

MAY 11 1956

RECEIVED

5623

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Pen. Gen. Hospt.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parsonsborg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION P.G. Hospt. Salisbury, Maryland.				d. STREET ADDRESS In Village			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Wilson Middle BURTON Last Lingo				4. DATE OF DEATH Month May Day 25 Year 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 21, 1908		9. AGE (In years last birthday) yrs. 47	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) R.D.# Millsboro, Del.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Robert Wilson Lingo				14. MOTHER'S MAIDEN NAME Nancy Ella Cordrey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Ethel E. Lingo (Wife) Address Parsonsborg, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592x Anemia DUE TO Nephritis, Chronic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anemia, Severe (Hypochromic)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/29, 1955 to 5/25, 1956 , that I last saw the deceased alive on 3/25, 1956 , and that death occurred at 12:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury Md. DATE SIGNED 5/25/56							
ACTUAL SIGNATURE David J. Gilmore M.D.				PHYSICIAN'S NAME (Type) Dr. David J. Gilmore M.D. Medical Center - Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 27, 1956		22c. NAME OF CEMETERY OR CREMATORY Parsonsborg Cemetery		22d. LOCATION (City, town, or county) (State) Parsonsborg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Holloway & Co. Salisbury, Maryland.				24. RECEIVED BY REGISTRAR MAY 28 1956			
				25. REGISTRAR'S SIGNATURE Mary H. Holloway			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

5624

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>Accomac</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12</u> <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW CHURCH, 838-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HERBERT</u> <u>MARSHALL</u>				4. DATE OF DEATH Month Day Year <u>MAY</u> <u>13</u> <u>1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April-9-1884</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>store</u>		9. AGE (In years last birthday) <u>72</u> yrs.	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Littleton F. Marshall</u>				14. MOTHER'S MAIDEN NAME <u>Esther A. Mills</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>227-240824</u>		17. INFORMANT <u>Wm T. Gladding</u> Address <u>New Church Va</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Yellow Atrophy of Liver</u> <u>092X</u> DUE TO (b) <u>Infectious (Viral) Hepatitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/28</u> , 19 <u>56</u> , to <u>5/13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David J. Gilmore</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury Del.</u> DATE SIGNED <u>May 14, 1956</u>			
PHYSICIAN'S NAME (Type) <u>DAVID J. GILMORE, MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>May 16-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Nelson Cemetery</u>		22d. LOCATION (City, town, county) (State) <u>Pocomoke Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u> ADDRESS <u>Pocomoke Md</u>				24a. REC'D BY REGISTRAR DATE <u>5/17/56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

BUREAU V. S.

MAY 17 1956

RECEIVED

5625

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General Hospital</u>				d. STREET ADDRESS <u>RURAL</u>			
3. NAME OF DECEASED (Type or print) <u>CORDELL H. NORTH</u> <u>Boy</u> <u>Northcutt</u>				4. DATE OF DEATH <u>May 28-1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 28-1956</u>	
9. AGE (In years last birthday) <u>28</u>		IF UNDER 1 YEAR <u>28</u> Months <u>28</u> Days <u>28</u> Hours <u>28</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>CORDELL H. NORTH CUTT</u>				14. MOTHER'S MAIDEN NAME <u>SHIRLEY ANN PHILLIPS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>CORDELL H NORTH CUTT</u> Address <u>Pocomoke Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>atelectasis</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity (6 1/2 mo) 3'-15"</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>5-28, 1956</u> , to <u>5-28, 1956</u> , that I last saw the deceased alive on <u>5-28, 1956</u> , and that death occurred at <u>9:20p M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>W. B. Smith</u> M.D. <u>DR. WILLIAM B. SMITH</u>				THE MEDICAL CENTER RT. 2, SALISBURY, MD.			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 5/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BASCOM CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>HILLTONIA GEORGIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S. Watson</u> ADDRESS <u>Pocomoke Md.</u>				24a. REC'D BY REGISTRAR <u>JUN 4 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

2082342 XVI

1956 77 NDC

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5826 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05628 33✓
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b 	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delmar</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>R F D 3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Wilson</u> Last <u>Parsons</u>				4. DATE OF DEATH Month <u>5</u> Day <u>8</u> Year <u>19 56</u>					
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-27-1935</u>		9. AGE (In years last birthday) <u>21</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Trucking</u>		11. BIRTHPLACE (State or foreign country) <u>Hebron, Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>James Edward Parsons</u>				14. MOTHER'S MAIDEN NAME <u>Thelma M. Haddock</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-30-7897</u>		17. INFORMANT <u>James Edward Parsons, Delmar, Del.</u>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Compound fracture of skull</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>810X</u> DUE TO (c) <u> </u> </div> <div style="width: 15%;"> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> </div> </div>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Driving a truck that collided with a train.</u>						
20c. TIME OF INJURY Month, Day, Year Hour <u>1</u> P. M. <u>5-8-56</u> 19 <u>56</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>R R tracks</u>		20f. (City or town) <u>Salisbury</u>		(County) <u>Wicomico</u> (State) <u>Md.</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>Earl L. Royer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>5-10-56</u>			
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-10-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Charity</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Md.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Marvel Co - Delmar, Del</u>				ADDRESS 		24a. REC'D BY REGISTRAR <u>5/11/56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary K. Holloway</u>	

TO PUBLIC MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a post-mortem is necessary, please execute it within 72 hours, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAY 11 1956

RECEIVED

[Handwritten signature]

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

337

5643

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury (Rural)				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Quantico Rd				d. STREET ADDRESS 827 S. Division St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First EDWARD Middle LEE Last PERRY , SR.				4. DATE OF DEATH Month May Day 9 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Dec 29, 1905	
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months 50 Days 50		IF UNDER 24 HRS. Hours 50 Min. 50			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone Employee				10b. KIND OF BUSINESS OR INDUSTRY Cable Splicer		11. BIRTHPLACE (State or foreign country) Salisbury, Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Richard F. Perry				14. MOTHER'S MAIDEN NAME Mary Emily Majors			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO.			
17. INFORMANT Mr. Richard A. Perry (Brother)				Address 201 New York Ave. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon-monoxide poisoning DUE TO 977.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Sudden DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased got in Trunk of Car Hose was connected to exhaust pipe of truck with end in trunk			
20c. TIME OF INJURY Month, Day, Year Hour o. m. P.M. p. m. 8-9-56 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road near Quantico Salisbury Wicomico Md.	
20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Earl L. Royer				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Dr. Earl L. Royer M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF May 12, 1956		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	
22d. LOCATION (City, town, or county) Salisbury, Maryland				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR May 10 1956	
				24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

TO PURCHASER MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If cause of death is necessary, please see page 4 of this form. Write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MAY 16 1956

RECEIVED

5627

CERTIFICATE OF DEATH

Reg. Dist. No.

33✓

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12</u> <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>9 mo.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Maryland</u> <u>3V01-4</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS <u>4312 Arabia Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Sophia</u> Middle <u>Anna</u> Last <u>Rever</u>				4. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>56</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 6, 1877</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>George W. Rever</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Klingler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>--</u>		17. INFORMANT <u>Deer's Head Hospital Records</u> Address <u>Salisbury, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, general</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic gastro-intestinal bleeding, site undetermined</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Salisbury, Maryland</u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>July 28</u> , 19 <u>55</u> , to <u>May 1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 1</u> , 19 <u>56</u> , and that death occurred at <u>10:45A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. J. Gore</u> M.D.				DATE SIGNED <u>5/1/56</u>			
PHYSICIAN'S NAME (Type) <u>R. J. Gore, M. D.</u>				Deer's Head State Hospital			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/4/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>OAKLAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MARYLAND.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HENRY SANDERS & SONS, INC.</u>				ADDRESS <u>Baltimore, Maryland</u>		24a. REC'D BY REGISTRAR <u>MAY 7 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAY 7 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5628

CERTIFICATE OF DEATH

05631

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital		d. STREET ADDRESS Fruitland	
3. NAME OF DECEASED (Type or print) First Ida Middle Shockley Last Shockley		4. DATE OF DEATH Month 5 Day 14 Year 1956	
5. SEX Female	6. COLOR OR RACE A.A.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1876
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 5 Days 14 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Housework	
11. BIRTHPLACE (State or foreign country) Snow Hill, Worcester Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Mary Shockley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Jane Roberts, Morris St. Fruitland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Insufficiency 725X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Decubital Ulcers (c) Polyarthritis		INTERVAL BETWEEN ONSET AND DEATH 1 week 3 months 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 5 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 15, 1955 to May 14, 1956 that I last saw the deceased alive on May 14, 1956 and that death occurred at 7:00 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE D. Herbert Semple M.D.		ADDRESS (Street, city or town, state) 400 E. Church St. Salisbury Md	
DATE SIGNED 5/16/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-18-56	
22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery		22d. LOCATION (City, town, or county) (State) Fruitland, Wicomico Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart ADDRESS Fruitland, Salisbury, Md.		24a. REC'D BY REGISTRAR MAY 21 1956	
24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

BUREAU V. S.

MAY 21 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5629 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05632
Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pen. Gen. Hospital				d. STREET ADDRESS R.D. # 3 (Old Delmar Rd)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) (BABY) First Middle Last SHORES				4. DATE OF DEATH Month Day Year May 2 nd 19 56				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 2, 1956		
9. AGE (In years last birthday) 0 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 3 Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Robert Parsons				14. MOTHER'S MAIDEN NAME Shirley XXXXXX Adkins Shores				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Lester J. Adkins (Grandfather) R.D. # 3 Old Delmar Rd - Salisbury, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital Abortion DUE TO Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Abortion, self induced DUE TO Abortion, self induced (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 hrs							INTERVAL BETWEEN ONSET AND DEATH 3 hrs	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE Earl L Royer M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) Dr. Earl L Royer				ASSISTANT MEDICAL EXAMINER EX				
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED May 3 1956				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 3, 1956		22c. NAME OF CEMETERY OR CREMATORY St. John Cemetery		22d. LOCATION (City, town, or county) (State) Powellville, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR DATE 5/4/56		
24b. REGISTRAR'S SIGNATURE Mary W. Holloway								

MEDICAL CERTIFICATION

TO BE FILLED BY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please see Chapter 18 of the Regulations, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MINNESOTA STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Manner of Death		Occupation		Education	
Residence		Birthplace		Date of Birth	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	

Handwritten signature and text, likely identifying the deceased or the medical examiner.

BUREAU V. S.

MAY 4 1956

RECEIVED

Handwritten signature and text, likely identifying the medical examiner or registrar.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5644 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05633

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural Salisbury</u>		c. LENGTH OF STAY IN 1b <u>less than 1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Renta 50, Highway, near Spring Hill Church.</u>				d. STREET ADDRESS <u>not known</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>A</u> Last <u>Slatcher.</u>				4. DATE OF DEATH Month <u>May</u> Day <u>24</u> Year <u>1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>May 10, 1875</u>		9. AGE (In years last birthday) <u>81.</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer (ret)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Plant Package & Basket</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Unknown</u>			
14. MOTHER'S MAIDEN NAME <u>unknown</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			
16. SOCIAL SECURITY NO. <u>221-07-8697A</u>				17. INFORMANT <u>Oliver Slatcher, son,</u> Address <u>Laurel Delaware</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial Hemorrhage</u> <u>725X</u> DUE TO <u>Automobile Accident.</u> Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile Accident</u>		20c. TIME OF INJURY Month, Day, Year <u>11:10</u> a. m. <u>May 24, 1956</u>					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>highway,</u>		20f. (City or town) (County) (State) <u>rt 50.</u> <u>Wicomico,</u> <u>Maryld</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Kendrick Mc. Cullough</u>		EXAMINER'S NAME (Type) <u>Kendrick Mc. Cullough, M.D.,</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/27/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Cem.</u>			
22d. LOCATION (City, town, or county) (State) <u>Laurel, Delaware</u>		24a. REC'D BY REGISTRAR <u>May 24, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry Williams</u>		ADDRESS <u>Federalburg, Md.</u>		DATE <u>May 1 1956</u>			

TO PUBLIC MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a death is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1956 JUN 1

RECEIVED

5630

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 6 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne			
				d. STREET ADDRESS Route # 1			
3. NAME OF DECEASED (Type or print) First Edna Middle Elmira Last Smith				4. DATE OF DEATH Month 5 Day 10 Year 19 56			
5. SEX Female		6. COLOR OR RACE A.A.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-30-1892	
				9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 10 Days 10 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher				10b. KIND OF BUSINESS OR INDUSTRY Public School			
				11. BIRTHPLACE (State or foreign country) Washington, D. C.			
13. FATHER'S NAME George W. Thomas				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT Mrs. Myrtle K. Rollins, Washington, D. C.				17. ADDRESS 4339 Hunt Place, N. E.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260 (b) Cerebral Arteriosclerosis DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 5 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus; Diabetic Acidosis				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 5/7 , 19 56 , to 5/10 , 19 56 , that I last saw the deceased alive on 5/10 , 19 56 , and that death occurred at 12:06 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE David J. Gilmore M.D.				ADDRESS (Street, city or town, state) Salisbury Md			
PHYSICIAN'S NAME (Type) David J. Gilmore				DATE SIGNED May 14 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-15-56		22c. NAME OF CEMETERY OR CREMATORY Princess Anne Cemetery		22d. LOCATION (City, town, or county) (State) Princess Anne, Somerset Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart				ADDRESS 324 E. Church St.			
DATE 5/16/56				REGISTRAR'S SIGNATURE Mary A. Holloway			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL HOME OR: After this certificate has been signed by the attending physician and completely filled in, the General Director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, place, cause, and signature. The form is mostly blank with some faint markings.

BUREAU V. E.

MAY 16 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05635

CERTIFICATE OF DEATH

Reg. Dist. No. 332

5631

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bishop</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Thomas</u>			4. DATE OF DEATH Month Day Year <u>May 14 - 1956</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 12 - 1956</u>		9. AGE (In years lost birthday) yrs. <u>7</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Douglas Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Stella Catherine Baker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>✓</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mother + Father, Bishop, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial Hemorrhage</u> 760.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5-12</u> , 19 <u>56</u> to <u>5-14</u> , 19 <u>56</u> that I last saw the deceased alive on <u>5-13</u> , 19 <u>56</u> , and that death occurred at <u>8:54</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Morris A. Lambdin</u>				ADDRESS (Street, city or town, state) <u>707 Camden, Salisbury Md</u>			
PHYSICIAN'S NAME (Type) <u>MORRIS A. LAMB DIN</u>				DATE SIGNED _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		22b. DATE THEREOF <u>5/15/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Peninsula General Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Peninsula General Hospital</u>				24a. REC'D BY REGISTRAR <u>May 15 - 1956</u>		24b. REGISTRAR'S SIGNATURE <u>May 15 - 1956</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John J. Smith</i>		DATE OF BIRTH <i>Jan 15 1885</i>		PLACE OF BIRTH <i>St. Louis, Mo.</i>	
MARRIAGE <i>Married</i>		DATE OF MARRIAGE <i>Jan 15 1910</i>		PLACE OF MARRIAGE <i>St. Louis, Mo.</i>	
CITY OF DEATH <i>Baltimore, Md.</i>		COUNTY OF DEATH <i>Harford</i>		STATE OF DEATH <i>Md.</i>	
DATE OF DEATH <i>May 17 1956</i>		PLACE OF DEATH <i>Home</i>		CAUSE OF DEATH <i>Heart Disease</i>	
DISEASE OR INJURY <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		OCCUPATION <i>None</i>	
EDUCATION <i>High School</i>		RELIGION <i>Catholic</i>		RACE <i>White</i>	
SEX <i>Male</i>		AGE <i>71</i>		HEIGHT <i>5' 8"</i>	
WEIGHT <i>175</i>		TEMPERATURE <i>98.6</i>		PULSE <i>72</i>	
BLOOD PRESSURE <i>120/80</i>		RESPIRATION <i>18</i>		DIET <i>Regular</i>	
SMOKING <i>None</i>		ALCOHOL <i>None</i>		DRUGS <i>None</i>	
PREVIOUS ILLNESS <i>None</i>		SURVIVAL <i>None</i>		POSTMORTEM <i>None</i>	
SIGNATURE OF DECEASED <i>John J. Smith</i>		SIGNATURE OF WITNESS <i>John J. Smith</i>		SIGNATURE OF PHYSICIAN <i>John J. Smith</i>	
DATE OF SIGNATURE <i>May 17 1956</i>		DATE OF SIGNATURE <i>May 17 1956</i>		DATE OF SIGNATURE <i>May 17 1956</i>	

BUREAU V. S.

MAY 17 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5632

CERTIFICATE OF DEATH

05636

33 ✓

Reg. Dist. No. 115

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>Since 4/25/56</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		<u>09-13-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pine Bluff State Hospital Salisbury, Maryland</u>				STREET ADDRESS (If rural give location) <u>4 Willis Street</u>			
3. NAME OF DECEASED (Type or Print) <u>Arthur Monroe Travers</u>				4. DATE OF DEATH (Month) <u>May</u> (Day) <u>25</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>April 10, 1891</u>	
9. AGE last birthday <u>65</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>15</u>		11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman & Painter</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Hoopers Island, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Charles Monroe Travers</u>				14. MOTHER'S MAIDEN NAME <u>Mary Lewis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>217-14-8078</u>		17. INFORMANT & ADDRESS <u>Wife - Edna Travers - same address as deceased</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Pulmonary Tuberculosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Asthma</u>						<u>3 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 25, 1956</u>, to <u>May 25, 1956</u>, that I last saw the deceased alive on <u>May 25, 1956</u>, and that death occurred at <u>3:15 p.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>S. Hurdle</u>				ADDRESS (Street, city, town, state) <u>Salisbury, Maryland</u>			
DATE <u>May 27, 1956</u>				DATE SIGNED <u>May 25, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 27, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u>		LOCATION (City, town, or county) <u>Cambridge, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>John H. ...</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth R. J. Homer Comb. Md.</u>		ADDRESS	

CERTIFICATE OF DEATH

1. PLACE OF DEATH

2. NAME OF DECEASED

3. SEX

4. AGE

5. DATE OF BIRTH

6. PLACE OF BIRTH

7. OCCUPATION

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF CORONER

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

16. SIGNATURE OF CLERK

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF DEPUTY SHERIFF

19. SIGNATURE OF CONSTABLE

20. SIGNATURE OF JAILER

21. SIGNATURE OF WARDEN

22. SIGNATURE OF CHIEF CLERK

23. SIGNATURE OF ASSISTANT CLERK

24. SIGNATURE OF RECEPTION CLERK

25. SIGNATURE OF DISCHARGE CLERK

26. SIGNATURE OF ADJUTANT GENERAL

27. SIGNATURE OF QUARTERMASTER

28. SIGNATURE OF SURGEON GENERAL

29. SIGNATURE OF ASSISTANT SURGEON GENERAL

30. SIGNATURE OF CHIEF OF MEDICAL DEPARTMENT

1. PLACE OF DEATH

2. NAME OF DECEASED

3. SEX

4. AGE

5. DATE OF BIRTH

6. PLACE OF BIRTH

7. OCCUPATION

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF CORONER

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

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17. SIGNATURE OF SHERIFF

18. SIGNATURE OF DEPUTY SHERIFF

19. SIGNATURE OF CONSTABLE

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24. SIGNATURE OF RECEPTION CLERK

25. SIGNATURE OF DISCHARGE CLERK

26. SIGNATURE OF ADJUTANT GENERAL

27. SIGNATURE OF QUARTERMASTER

28. SIGNATURE OF SURGEON GENERAL

29. SIGNATURE OF ASSISTANT SURGEON GENERAL

1. PLACE OF DEATH

2. NAME OF DECEASED

3. SEX

4. AGE

5. DATE OF BIRTH

6. PLACE OF BIRTH

7. OCCUPATION

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF CORONER

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

16. SIGNATURE OF CLERK

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF DEPUTY SHERIFF

19. SIGNATURE OF CONSTABLE

20. SIGNATURE OF JAILER

21. SIGNATURE OF WARDEN

22. SIGNATURE OF CHIEF CLERK

23. SIGNATURE OF ASSISTANT CLERK

24. SIGNATURE OF RECEPTION CLERK

25. SIGNATURE OF DISCHARGE CLERK

26. SIGNATURE OF ADJUTANT GENERAL

27. SIGNATURE OF QUARTERMASTER

28. SIGNATURE OF SURGEON GENERAL

29. SIGNATURE OF ASSISTANT SURGEON GENERAL

BUREAU V. A.

MAY 29 1956

RECEIVED

5633

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>1 hour</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Powellville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Minas</u> Middle <u>EDWARD</u> Last <u>TRUITT</u>				4. DATE OF DEATH Month <u>5</u> Day <u>13</u> Year <u>19 56</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAR. 4, 1897</u>		9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WOOD CUTTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SAW MILL</u>		11. BIRTHPLACE (State or foreign country) <u>POWELLVILLE MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES TRUITT</u>				14. MOTHER'S MAIDEN NAME <u>ELIZA LEWIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-12-196</u>		17. INFORMANT Address <u>MRS. MAGGIE DENNIS POWELLVILLE MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carbon monoxide poisoning</u> <u>916.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Found unconscious and taken out of burning building</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>12:45 P.M.</u> <u>5-13</u> <u>19 56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Farmhouse</u>		20f. (City or town) (County) (State) <u>Powellville</u> <u>Wicomico</u> <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>5-16-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY 16 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>RIVERSIDE</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna R. Burbage Berlin and</u>				24a. REC'D BY REGISTRAR <u>DATE 5-19-56</u>		24b. REGISTRAR'S SIGNATURE <u>May M. Holladay</u>	

MEDICAL CERTIFICATION

TO THE FUNERAL EXAMINER: This certificate should be executed within 24 hours after death. If only a preliminary examination is made, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAY 21 1956

RECEIVED

[Handwritten signature]

5634

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 82 Pen. Gen. Hospital				d. STREET ADDRESS N. Pineway R.D. # 5			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle BRYAN Last TRUITT				4. DATE OF DEATH Month MAY Day 8 th Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night Watchman at Wayne Pump Co.				10b. KIND OF BUSINESS OR INDUSTRY Pittsville, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME L. Teagle Truitt				14. MOTHER'S MAIDEN NAME Emma C. Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> Yes		(If yes, give war or dates of service) W.W. # 1		16. SOCIAL SECURITY NO. W.W. # 1			
17. INFORMANT Mrs. Delda I. Truitt (Wife)				Address R.D. # 5 Pineway Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH Delayed
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from 3/28 , 19 57 , to 5/3 , 19 57 , that I last saw the deceased alive on 5/3 , 19 56 , and that death occurred at 10:30 PM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE Fred B. Gramse M.D.				S. Division St May 4 1956			
PHYSICIAN'S NAME (Type) Dr. Fred Gramse				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 6, 1956		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR MAY 8 1956	
				24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

MEDICAL CERTIFICATION

BUREAU V. S.

MAY 8 1956

RECEIVED

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, IS

5635

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Hill Nursing Home				d. STREET ADDRESS 119 Fooks St			
3. NAME OF DECEASED (Type or print) First CLAYTON Middle C Last WILLING				4. DATE OF DEATH Month MAY Day 4 Year 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 21, 1878	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sexton at Church			10b. KIND OF BUSINESS OR INDUSTRY Sexton	11. BIRTHPLACE (State or foreign country) Salisbury, Maryland	12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME George Willing				14. MOTHER'S MAIDEN NAME Annie Dare			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Milford W. Twilley (Daughter) Address Mt. Hermon Rd Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiovascular Renal Disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from _____, 19 54 , to 5-4 , 19 56 , that I last saw the deceased alive on _____, 19 _____ and that death occurred at 5:29 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Phleggy Insley M.D.				ADDRESS (Street, city or town, state) Main St. Salisbury, Maryland		DATE SIGNED May 4 1956	
PHYSICIAN'S NAME (Type) Dr. P.H. Insley							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 6, 1956	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND				24a. REC'D BY REGISTRAR MAY 8 1956		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]	
PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]		DATE OF BIRTH [Faint text, possibly "Jan 15, 1910"]		PLACE OF DEATH [Faint text, possibly "Baltimore, Md."]	
OCCUPATION [Faint text, possibly "Teacher"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]	
DATE OF DEATH [Faint text, possibly "May 5, 1956"]		TIME OF DEATH [Faint text, possibly "10:30 AM"]		PLACE OF INTERMENT [Faint text, possibly "St. Mary's Cemetery"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF CORONER [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]	

BUREAU V. S.

MAY 8 1956

RECEIVED